George W. Stevens

Dept. Veterans' Affairs

NKM07257

George Stevens, NKM07257 VRB Page Summary

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52	18/06/2008	Medical Impairment Assessment - Disfigurement and Social Impairment
53 to 58	23/11/2007	Combined Impairment Report
59 to 73	23/07/2008	Decision and Reasons for Decision
74 to 75.	6/10/2008	My Request for Review of Decision
76	28/10/2008	Last Page of Sylvestre Report
77	12/01/2009	Case Manager Letter
78 to 79	16/12/2008	Clarification Form and my Attachment
80	24/03/2009	Case Manager Letter
81 to 82	12/03/2009	Accoustic Report
83	27/02/2009	My letter to Review Support Officer.

Australian Government
Department of Veterans' Affairs

DEPARTMENTAL SECTION 137 REPORT FOR REFERRAL TO VETERANS' REVIEW BOARD UNDER VETERANS' ENTITLEMENT ACT 1986

Veteran's Details

Name: George Stevens

Address: Po Box 18
Berowra Heights 2082

Telephone: 02/94564007

Date of Birth: 10 February 1929

D.V.A File no. : KM07257
V.R.B No: N08/1126
Type: ASS
Service No: 32734
Arm of Service: NAVY
D.P. rate 90%
effective from 23/11/2007

- **DECISION UNDER REVIEW: Repatriation Commission Decision dated 23 July 2008, that bilateral angle closure glaucoma, GORD, chronic gastritis, diverticular disease, IHD with congestive cardiac failure, colorectal adenoma with iron deficiency anaemia and conductive haring loss are not related to service. DP is increased to 90%.**

HISTORY OF APPLICATION	
Date of lodgement of informal claim/application	
Date of lodgement of formal claim/application	23/11/2007
Date of primary decision	23/07/2008
Date of notification of primary decision	23/07/2008
Date of lodgement of application to Veterans' Review Board	08/10/2008

Attached are tables of the following
1. Veteran Community Details Report
2. Section 137 Index to Documents
3. Cover prepared by Sue Wardropper

Veteran Community Details Report

Australian Government
Department of Veterans' Affairs

NKM07257 , GEORGE W STEVENS , Veteran, ACTIVE FILENO

Contact Details

Postal Address ..... Po Box 18

Berowra Heights Nsw 2082

Residential Address ..... 16 Wymah Cres

Berowra Heights Nsw 2082

Residential (Internet) ..... (02) 9456 4007

Telephone Allowance ..... Yes

Service Details

24/09/1946, 02/01/1949, Navy, R32734

27/10/1953, 02/06/1954, Navy, R32734

22/03/1945, 31/05/1945, Australian Mariner

Qualifying Service Details

Australian - World War 2, Approved, 15/06/2002

Australian Government

Department of Veterans' Affairs

S.137 REPORT TO THE VETERANS' REVIEW BOARD INDEX SHEET

Name: **George STEVENS** DVA File No: **KM07257**

Date Received	Description of Document	DVA M File Folio	Report Folio	T Doc. No.
23/11/07	Lifestyle questionnaire dd 18/11/07	133-136	3-9	T3
23/11/07	Claim	137-144	10-26	T4
2/1/08	Audio dd 20/12/07	163-164	27-28	T5
9/7/08	Dr Antoon's reports/medical impairment assessment forms dd 18/6/08	180-203	29-52	T6
23/11/07	Combined impairment assessment	223-228	53-58	T7
23/7/08	R C Decision	231-245	59-73	T8
8/10/08	Application for VRB review	247-248	74-75	T9
28/10/08	Section 31 non-intervention file minute	249	76	T10

Report compiled by Lee Domecillo on 21/11/08
Photocopied by Vasantha

T2

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Australian Government

Department of Veterans' Affairs

Lifestyle Questionnaire

(Revised in consultation with ex-service organisations)

You should only complete this form if you want the Department of Veterans' Affairs to assess a lifestyle rating for you based on the information you provide.

It is **important** to remember that, when assessing your lifestyle, you should only claim for effects of disabilities that:

- **are war and/or defence caused;** and
- **have been accepted by the Department;** or
- **you are claiming for in this disability claim.**

Any disabilities that are **not** war and/or defence caused will **not** be considered when assessing your lifestyle rating.

The form has four parts of equal importance:

- **personal relationships;**
- **mobility;**
- **recreational and community activities;** and
- **domestic and employment activities.**

The information you provide on this form will assist in determining your rate of pension. The information will be treated in a confidential manner. In certain circumstances, however, it may be disclosed to:

- your Local Medical Officer to provide assistance to you; or
- the Veterans' Review Board, the Administrative Appeals Tribunal, or the Federal Court in the event of an appeal against a decision.

Only answer the questions that you consider apply to your accepted or newly claimed disabilities. You are not obliged to answer questions you do not want to, or questions that are not relevant to you.

If you need help

You may wish to discuss your lifestyle with your spouse, other family members or a friend. It may be in your interest to talk to an ex-service organisation welfare officer or other qualified person. If you need more information or have difficulty filling out the appropriate form, please contact the Department of Veterans' Affairs in your State on the numbers on the following page.

When completed please return this form to the Department of Veterans' Affairs in your State.

D2669 - 12/04 - p1

Personal Details

Your surname

STEVENS

Given names

GEORGE WOODFULL

Date of birth

10/2/1929

Veterans' Affairs file no. or your service no.

NKM 07257

Your signature

George Stevens 18/11/07

Personal Relationships

This concerns how well you get on with other people.

1. Which of the following statements apply to you? ***(You may tick more than one box).***

- ☐ Your personal relationships are unaffected by your disabilities.
- ☑ You are sometimes tense and a little anxious but still get on well with most people most of the time.
- ☐ You are often tense and irritable but still get on with some people fairly well.
- ☑ You don't sleep well.
- ☑ You often get cranky from pain.
- ☐ You find it difficult to discuss your problems.
- ☐ You are moody and irritable most of the time and usually find it difficult to get on with people.
- ☐ You are withdrawn and find it difficult to get on with other people.
- ☐ You have to depend on other people a lot.
- ☐ Your life is completely ruined.

2. How do you believe that your disabilities cause the above problems?

THE BACK PAIN CAUSES ALL THOSE PROBLEMS. IT IS PRESENT ALL THE TIME

3. Do your disabilities affect your life with your family?

No ☐ Yes ☑ - please describe in what way

THEY WORRY ABOUT ME

4. Do your disabilities affect your social life ?

No ☐ Yes ☑ - please describe in what way

QUITE LIMITED OCCASIONS WHEN I AM ABLE TO PARTICIPATE IN ANY SOCIAL EVENT

5. Has there been a change in the way you get on with other people since the disabilities occurred (or got worse)?

No ☑ Yes ☐ - please describe in what way

6. *This question is optional.*
Do your disabilities affect your sexual feelings or abilities?

No ☐ Sometimes ☐
Yes ☑ Affected by medication and/or treatment ☐

You may describe if you wish

I HAVE NO INTEREST IN SEX

7. Does your medication affect your family or social life?

No ☐ Yes ☑ - please describe in what way

THE CELEBREX DRUG REQUIRES ME TO MAINTAIN QUICK ACCESS TO TOILET FACILITIES. THE PANADOL PAIN KILLERS SOMETIMES DON'T WORK & I GET CRANKY

Mobility

This means your ability to move around in your usual surroundings. Your usual surroundings include your home that you usually visit. For example, church, shops, friends' houses.

It also includes your ability to use public transport or private cars to reach these locations and places.

8. Do you have any problems walking?
(Types of problems you may have affecting your mobility could include shortness of breath, or pain etc.)

No ☐ Yes ☑ - please give details below

Type of problem	How often it occurs *(please tick)*	
1. ENDURANCE LOSS BACK PAIN STAIRS DISTANCES ONLY GO A FEW 100 METRES	All of the time ☑	Some of the time ☐
	Most of the time ☐	Hardly ever ☐
	Depends on what I do and how fast I do it ☐	
2. CLIMBING / DESCENDING STAIRS	All of the time ☑	Some of the time ☐
	Most of the time ☐	Hardly ever ☐
	Depends on what I do and how fast I do it ☐	
3. LIMITED ABILITY TO CARRY WEIGHT	All of the time ☑	Some of the time ☐
	Most of the time ☐	Hardly ever ☐
	Depends on what I do and how fast I do it ☐	
4. SLOW PACE ONLY	All of the time ☑	Some of the time ☐
	Most of the time ☐	Hardly ever ☐
	Depends on what I do and how fast I do it ☐	
5.	All of the time ☐	Some of the time ☐
	Most of the time ☐	Hardly ever ☐
	Depends on what I do and how fast I do it ☐	

9. Do you need something to help you move around, (crutches, wheelchair etc.)?

No ☐ Yes ☑ - what do you use?

WALKING STICK, ESPECIALLY NEGOTIATING STAIRS

How often do you use the device?

All of the time ☑

Only sometimes ☐

10. Do you need fittings in your house to assist mobility ?

No ☐ Yes ☑ - please describe in what way

NO STAIRS OR STAIRS, RAMP OR LEVEL ACCESS

11. Do you need someone to help you move around or to go with you?

No ☐ Yes ☑ - what type of help do you need?

GETTING IN AND OUT OF CARS

12. Are there restrictions on your ability to sit in, or drive a car?

No ☐ Yes ☑ - please describe the restrictions

AFTER 15 MINUTES OR SO I AM VERY STIFF IN THE BACK. A SEPARATE PROBLEM IS THAT THE GLAUCOMA RESULTS IN POOR NIGHT VISION - I AM APPREHENSIVE ABOUT NIGHT DRIVING

13. Are there any forms of transport which you normally use, but have difficulty using?

No ☐ Yes ☑ - what forms of transport?

MOTOR CAR & ANY TRANSPORT WITHOUT I CAN'T GET A SEAT

What difficulties do you have using the transport?

WITHOUT SUITABLE, TRAVELLING IS PAINFUL (IN THE BACK)

How often do the difficulties occur?

All of the time ☑ BUT I LIMIT TRAVEL TO AN ABSOLUTE MINIMUM

Only sometimes ☐

Recr ıtion and Community Activities

This concerns your ability to take part in social activities.

/24

14. How often do you do the following things?

	A lot every day	*A little every day*	*2 or 3 times weekly*	*Monthly*	*Rarely or never*	*Weekly or fortnightly*
Visit or have visitors (e.g. friends or relatives)	☐	☐	☑	☐	☐	☐
Go out (e.g. to church, to watch sport, for entertainment, for meals or walks)	☐	☐	☐	☑	☐	☐
Play a sport (e.g. golf, tennis, bowls, fishing)	☐	☐	☐	☐	☑	☐
Do a hobby (e.g. craft, music, art, stamp collecting cards, woodwork)	☐	☐	☑	☐	☐	☐
Relax (e.g. reading, watching TV, listening to music)	☐	☑	☐	☐	☐	☐
Do voluntary work (e.g. meals on wheels, welfare officer at RSL, Legacy)	☐	☐	☐	☐	☑	☐

15. Do you have difficulty doing any other activities because of your disabilities? No ☑ Yes ☐ - please describe the difficulties

16. Are there any activities you have given up because of your disabilities ? No ☐ Yes ☑ - what are the activities?

MINOR HOME MODIFICATIONS eg BUILD SHELVES, PAINT ROOMS, CHANGE LIGHT FITTINGS, CHANGE TAP WASHERS

Domestic and Employment Activities

This concerns your ability to carry out common household tasks and your ability to work.

Domestic Activities

17. How well can you do the following things?

	Easily	*With difficulty*	*With help*	*If I take my time*	*I can't do it*	*I don't need to*	*Not Applicable*
Grocery shopping	☐	☐	☐	☑	☐	☐	☐
House cleaning	☐	☑	☐	☑	☐	☐	☐
Washing up	☑	☐	☐	☐	☐	☐	☐
Minor house repairs	☐	☑	☐	☑	☐	☐	☐
Light gardening such as weeding and watering	☐	☑	☐	☑	☐	☐	☐
Heavy gardening such as digging and pruning trees	☐	☐	☐	☐	☑	☐	☐
Lawn mowing	☐	☐	☐	☐	☑	☐	☐
Washing the car	☐	☑	☐	☑	☐	☐	☐
Lifting	☐	☑	☐	☐	☐	☐	☐
Cooking	☑	☐	☐	☐	☐	☐	☐
Sewing	☐	☐	☐	☐	☐	☐	☑
Knitting	☐	☐	☐	☐	☐	☐	☑

18. Are there any domestic activities you have stopped doing because of your disabilities?

No ☐ Yes ☑ - what are the activities?

HOME IMPROVEMENTS
MINOR REPAIRS
WINDOW CLEANING

19. Are there any domestic activities which you have difficulty doing or take you longer than they used to?

No ☐ Yes ☑ - describe the difficulties

GENERAL TIDYING UP INC THE YARD. PUTTING OUT THE RUBBISH BINS. CHANGING BLOWN LIGHT GLOBES

20. Does someone do things for you that you used to do?

No ☐ Yes ☑ - please describe these things

LAWN MOWING
HEAVY GARDENING

Employment Activities

21. Are you employed?

No ☑ - go to Question **31**

Yes ☐ - go to Question **22**

22. What is your occupation?

23. Is your employment full-time, part-time or casual?

24. How many hours per week do you normally work?

25. Have you changed jobs in the last 5 years?

No ☐ Yes ☐ - why did you change jobs?

26. Are there things you can't do at work that you used to do?

No ☐ Yes ☐ - what things can't you do?

Why are unable to do them?

27. Have you changed your workplace or the way you work to make it easier?

No ☐ Yes ☐ - what changes have you made?

Why did you make these changes?

28. Hav u changed the hours you normally work?

No ☐ Yes ☐ - why did you change the hours?

29. Have you lost any time from work during the past 12 months because of your disabilities?

No ☐ Yes ☐ - how much time have you lost?

30. In your opinion, have your disabilities affected your future or career?

No ☐ - go to **Summary**

Yes ☐ - please describe in what way

Now go to **Summary**

For those who have stopped working

31. What year did you stop working?

1986

32. Why did you stop working?

Age ☐

Ill-health ☐

Other ☑ - please give reasons

WANTED TO WORK WITHOUT SUPERVISION & TO ACHIEVE MY OWN OBJECTIVES IN DOING COMMUNITY WORK (VOLUNTARY)

33. Did your disabilities stop you working in any way?

No ☐ Yes ☐ - please describe in what way

NOT INITIALLY, BUT DID SO AFTER A FEW YEARS

34. Have you sought or do you intend to seek employment?

No ☑ - go to **Summary**

Yes ☐ - will your disabilities have any effect on your chance of employment?

No ☐

Yes ☐ - please describe in what way

Summary

In this section you can put in your own words the effect your disabilities have on your lifestyle.

35. List the main ways your disabilities affect the way you live now.

I HAVE QUITE LIMITED PHYSICAL MOBILITY & I HAVE CONSTANT BACK PAIN - SOMETIMES MILD, SOMETIMES PRONOUNCED THIS HINDERS/ELIMINATES MY OPPORTUNITIES TO PARTICIPATE IN GROUP/SOCIAL EVENTS,

Use this space if you would like to tell us further details about the effect your disabilities have on your lifestyle.

THE LEVEL OF FRUSTRATION IS HIGH. FOR MANY YEARS I HAVE HAD BOTH THE ABILITY AND MOTIVATION TO ACHIEVE IN PROJECTS. NOW THE MOTIVATION IS STILL THERE BUT THE ABILITY HAS CHANGED. MY 78 YEAR OLD BRAIN IS STILL VERY ACTIVE BUT THE 71 YEAR OLD BODY SIMPLY REFUSES TO OBEY THE LAWFUL CEREBRAL COMMANDS THAT I GIVE, THIS DESPITE THE BELIEF THAT I WILL SURVIVE FOR AT LEAST ANOTHER 10 TO 15 YEARS.

When you have completed this form please return it to the Department of Veterans' Affairs. The addresses are on page two of this form.

PART A Representative's details

To be completed only if you wish to nominate a representative to act for you in matters relating to this application

T4 002 503 144

1 Do you wish to nominate a representative or organisation to act for you in matters related to this claim?

No ☐ ▶ Go to **Question 3**

Yes ☒ ▶ Full name of nominated representative

MICHAEL SHAVE ACKNOWLEDGED

Organisation *(if applicable)*

VVFA

Address P.O. Box 170.

GRANVILLE

POSTCODE 2142.

DEPARTMENT OF VETERANS' AFFAIRS
NEW SOUTH WALES
RECEIVED
23 NOV 2007

Telephone

Home	Work
( )	( ) 9682 1788

Facsimile	E-mail address
( )	

2 Is the representative trained under the Training and Information Program (TIP)?

No ☐

Yes ☐ ▶ To what level?

PART B Veteran's details

3 DVA file number (if known) NKM 07257

4 Title (Mr, Mrs, Dr etc.) Mr.

5 Surname STEVENS

6 Given name(s) GEORGE WOODFULL

7 Residential address 16 WYMAH CRESCENT
BEROWRA HEIGHTS POSTCODE 2082

8 Postal address (if same as residential, write 'As Above') PO BOX 18
BEROWRA HEIGHTS POSTCODE 2082

9 Telephone numbers

Home	Work
(02) 9456 4007	( ) ✓

10 Date of birth 10 / 2 / 1929

11 Marital status Married ✓ Single ☐ Widowed ☐ Divorced ☐ De-facto ☐

12 **Next-of-kin's name** NANCY SHIRLEY STEVENS

13 **Relationship to veteran** WIFE

14 **Next-of-kin's address** 16 WYMAH CRESCENT
BURWOOD HEIGHTS POSTCODE 2082

15 **Next-of-kin's telephone numbers** Home (02) 9456 4007 Work ( )

PART C What type of application are you making?

Tick the box or boxes that apply.

A. Claim for Disability Pension for disabilities that have not yet been accepted as service related [X] ▶ **Complete ALL questions** (unless advised differently by question notes)

AND/OR

B. Application for Increase in Disability Pension for previously accepted disabilities (if your already accepted disabilities have worsened) [X] ▶ **Complete ALL questions from Question 25 onwards** (unless advised differently by question notes)

16 **Have you claimed a disability or service pension from this Department before?**
No [ ] ▶ Go to **Question 18**
Yes [✓] ▶ In which State was the claim lodged? NSW Year lodged *(if known)* 1980

17 **Have you had further service since your last claim?**
No [✓] ▶ Go to **Question 20**
Yes [ ] ▶ Go to **Question 18**

PART D Your service details

18 **Please provide known details of your service in Australian forces and forces of other countries**
If insufficient space, please attach a separate sheet giving the required details

NOTE: The Department of Veterans' Affairs will approach the Department of Defence for full details of your service. The information you provide will ensure the inquiries are directed to the appropriate area within Defence.

Service number	Unit or branch of service *(include part-time reservist)*	Enlistment and discharge dates *(show actual dates, if known)*	Nature of duties
	SEE FILE		
		/ / to / /	
		/ / to / /	
		/ / to / /	

Merchant Mariners only

Name of ship	Rank or grade	Name of owner or manager	Port of registration	Non-Australian ports visited	Voyage dates
					From / /
					To / /
					From / /
					To / /

If insufficient space, please attach a separate sheet

19 Did you serve under any other name? No ☐ Yes ☐ ▶ What was the name?

PART E Details of the NEW disabilities you are now claiming as war or defence caused

If you are not claiming for acceptance of new disabilities go straight to **Question 25.**

To be filled in by the VETERAN

20 List the disabilities you are now claiming and describe the signs and symptoms.

Please provide the diagnosis of the disability, if you know what it is. If you don't know what the diagnosis is, please describe as fully as you can the signs and symptoms that make you notice the disability (for example, pain in lower back, shortness of breath, loss of range of movement in arm).

Do not include any injury or disease already accepted as war or defence caused.

You are requested to ask your doctor to fill in the Medical Practitioner column next to this section before lodging your claim.

Disability 1 GLAUCOMA

Signs and symptoms REFER OPHTHALMIC SURGEON DR. D. SYMPTOMS REPORT DATED 7/5/2003 COPY ATTACHED. PRESSURES CHECKED EVERY 3 MONTHS. MEDICATION NOW LUMIGAN ATTACHMENT # 1

How do you believe your service caused, contributed to, or aggravated this disability?

THERE IS NO FAMILY HISTORY OF THIS. AS THE CONDITION WAS DIAGNOSED SOON AFTER 14 YEARS OF CONTINUOUS NAVAL SERVICE, IT COULD BE ARGUED THAT THIS SERVICE SOMEHOW CONTRIBUTED TO THE ONSET OF THIS CONDITION. CAUSED BY CATARACTS.

When did you first become aware of the signs and symptoms of the disability, or aggravation of the disability? (approx. date if known) (ALREADY ACCEPTED).

To be filled in by a MEDICAL PRACTITIONER

For each disability the veteran is claiming, provide a diagnosis indicating whether the diagnosis is final or provisional. A final diagnosis is preferred.

Please supply a brief summary of the basis for each diagnosis. Please attach any reports you have that confirms the diagnosis/es.

The Department will pay you for this service according to *The Schedule of Fees*.

Note: An account must be lodged before payment can be made.

Medical diagnosis

Diagnosis GLAUCOMA

Basis for diagnosis eye specialist

When did the veteran first consult you for this condition?

NOV. 2004.

PART E (continued)

DETAILS O... N DISABILITIES YOU ARE NOW CLAIMING AS WAR OR DEFENCE CAUSED

Disability 2 ANAEMIA

Signs and symptoms

REFER ATTACHED BLOOD TEST RESULTS DATED 10/7/07, 29/9/07, 12/10/07, 31/10/07

ATTACHMENT # 2.

Medical diagnosis

Diagnosis ANAEMIA

Basis for diagnosis D- CHRONIC (Gastroenterologist) 2nd to polyps (colonic)

How do you believe your service caused, contributed to, or aggravated this disability?

I AM UNABLE TO GIVE A DEFINITIVE RESPONSE TO THESE 2 QUESTIONS, OTHER THAN TO STATE THAT I FEEL THAT SOME OF THE MEDICATION PRESCRIBED TO EASE THE DISCOMFORT AND PAIN OF THE

When did you first become aware of the signs and symptoms of the disability, or aggravation of the disability? (approx. date if known)

When did the veteran first consult you for this condition?

JUNE 2007

Disability 3 REFLUX OESOPHAGITIS, GASTRITIS, DIVERTICULAR DISEASE, COLON POLYPS

Signs and symptoms

REFER ATTACHED REPORT DATED 31/8/07 FROM DR GILES FOOK CLOSED

ATTACHMENT # 3

Medical diagnosis

Diagnosis REFLUX OESOPHAGITIS GASTRITIS DIVERTICULAR DISEASE

Basis for diagnosis D/ CHRONIC

How do you believe your service caused, contributed to, or aggravated this disability?

SPONDYLOSIS CONDITION, SUCH AS THE NOW BANNED DRUG BUTAZOLIDIN, HAS CUMULATIVELY HAD DELETERIOUS EFFECTS ON MY GASTRIC HEALTH OVER THE PAST 50 PLUS YEARS.

When did you first become aware of the signs and symptoms of the disability, or aggravation of the disability? (approx. date if known)

When did the veteran first consult you for this condition?

JUNE 2007

IMPORTANT - So that your claim can be processed quickly:

- please have your doctor provide a diagnosis for each disability you are now claiming; and
- provide all relevant documents you may have relating to the disabilities.

Please attach a separate sheet if you wish to claim for more than three (3) disabilities at this time.

Doctor's stamp (or address and telephone number)

DR JOHN ANTOON
1A TURNER ROAD
BEROWRA HEIGHTS NSW 2082
Ph: 9456 2600
( )

VRGP ✓ Non VRGP ☐

Doctor's signature

21/11/07

Payment for your account for this service can only be made after this form has been received.

NKM07257 – George W. Stevens

Part E

Disability 4.

Fluid around the heart and lungs

Refer attached Northside Medical Imaging – 53 report dated 5 November 2007.

Possible or contributory cause was working in stressful circumstances for a number of years in operational aircraft carriers, in particular during periods of military conflict, eg Korea, FESR.

8 CIGARETTE SMOKING.
ATTACHMENT # 4

Medical Diagnosis

Diagnosis CCF

Basis for diagnosis CT SCAN
under ONGOING
treatment
investigations

When did the veteran first consult you for this condition?

JAN 2007.

Part H – Details of Medical Treatment
NKM07257 – George W Stevens

Lumbar Spondylosis	A	1964 to 1971	Dr B Poynton	GP
		1996.	Dr E Basset	GP
Solar Kerotoses	A	2003	Dr B Killalea	GP
Tinnitus	A	2003	Dr B Kilalea	GP
Cataracts	A	2003 to 2004	Dr D Semmonds	Specialist
Glaucoma	NC	1982 to 2007	Dr D Rich	Specialist
			Dr S Hollo	Specialist
			Dr D Semmonds	Specialist
Reflux Oesophagitis	NC	2007	Dr J Antoon	GP
Gastritis	NC	2007	Dr M Bourke	Specialist
Diverticular disease	NC	2007	Dr C Choong	Specialist
Fluid around heart	NC	2007	Dr J Antoon	GP
		2007	Dr A Aggarwala	Specialist
		2007	Dr G Goldin	Specialist
		2007	Dr R Brahmbhatt	Specialist
Anaemia	NC	2007	Dr J Antoon	GP

A = previously accepted as service related.
NC = new claim

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COMMONWEALTH DEPARTMENT OF
VETERANS' AFFAIRS

Additional Information Sheet

NOTE: This is **not** a claim form and must be used as an attachment to form D2582 *'Claim for Disability Pension and/or Application for Increase in Disability Pension'*

Details of the NEW disabilities you are now claiming as war or defence caused

This column is to be filled in by the **Veteran**

List the disabilities you are now claiming and describe the signs and symptoms.

Please provide the diagnosis of the disability, if you know what it is. If you don't know what the diagnosis is, please describe as fully as you can the signs and symptoms that make you notice the disability (for example, pain in lower back, shortness of breath, loss of range of movement in arm).

Do not include any injury or disease already accepted as war or defence caused.
You are requested to ask your doctor to fill in the Medical Practitioner column next to this section before lodging your claim.

This column is to be filled in by a **Medical Practitioner**

For each disability that the veteran is claiming, provide a diagnosis indicating whether the diagnosis is final or provisional. A final diagnosis is preferred. **Please supply a brief summary of the basis for each diagnosis.** Please attach any reports you have that confirms the diagnosis/es.
The Department will pay you for this service according to *The Schedule of Fees.* **Note:** An account must be lodged before payment can be made.

Disability 5 — HEARING LOSS.

Signs and symptoms — TROUBLE HEARING TV, RADIO, CONVERSATIONS,

Medical Diagnosis

Diagnosis

Basis for diagnosis

How do you believe your service caused, contributed to, or aggravated this disability?

IN THE NAVY I WAS EXPOSED TO VERY LOUD AIRCRAFT NOISE ON CARRIER FLIGHT DECKS, NO EAR PROTECTION WORN. ALSO EXPOSED TO LOUD GUNFIRE.

When did you first become aware of the signs and symptoms of the disability, or aggravation of the disability? *(approx. date if known)*

When did the veteran first consult you for this condition?

Disability 5

Signs and symptoms

How do you believe your service caused, contributed to, or aggravated this disability?

When did you first become aware of the signs and symptoms of the disability or aggravation of the disability? *(approx. date if known)*

Medical Diagnosis

Diagnosis

Basis for diagnosis

When did the condition first appear?

Disability 6

Signs and symptoms

How do you believe your service caused, contributed to, or aggravated this disability?

When did you first become aware of the signs and symptoms of the disability or aggravation of the disability? *(approx. date if known)*

Medical Diagnosis

Diagnosis

Basis for diagnosis

When did the condition first appear?

Doctor's stamp (or address and telephone number)

( )

VRCS ☐ Non-VRCS ☐

Doctor's signature

/ /

portant

So that your claim can be processed quickly:

- ***please have your doctor provide a diagnosis for each disability you are now claiming; and***
- ***provide all relevant documents you may have relating to the disabilities.***

Payment of your account for this service can only be made after this form has been received.

PART F Tobacco and Alcohol

IMPORTANT - Some conditions may be caused, contributed to, or aggravated by tobacco or alcohol consumption. If tobacco or alcohol consumption is relevant to any of the conditions your are now claiming, more information may be needed by the person handling your claim. Please tick the relevant boxes below so that the correct questionnaire can be sent to you or your representative. 141

21 Have you ever smoked? No ☐ Yes ☑ What type of tobacco product did the veteran use?
Cigarettes ☑
Pipe ☐
Cigars ☐
Tobacco ☐

22 Have you filled out a smoking questionnaire previously? No ☐ Yes ☑ Can't remember ☐

23 Have you ever consumed alcohol? No ☐ Yes ☑

24 Have you filled out an alcohol questionnaire previously? No ☐ Yes ☑ Can't remember ☐

PART G Reasons for this application for increase

To be completed only if previously accepted disabilities have become worse.

25 Which of your accepted disabilities have become worse since they were last assessed by the Department and in what way?

* Lumbar Spondylosis
Hearing loss has increased
Bilateral keratosis
* Cataracts

FOR EXPLANATIONS OF HOW EACH OF THESE CONDITIONS HAS CHANGED SINCE THE LAST ASSESSMENT DURING MARCH 2003, PLEASE SEE ATTACHED STATEMENT "GEORGE W. STEVENS DISABILITY PENSION REVIEW NOVEMBER 2007"

ATTACHMENT # 5

If insufficient space, please attach a separate sheet.

PART H Details of your medical treatment

26 Provide details of doctors and hospitals who have provided treatment or consultation for the disabilities which have been accepted as service related or those you are now claiming.

Disability treated	Date of treatment	Name of doctor/hospital etc.	Type of treatment or consultation provided *(e.g. GP, specialist)*
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		

If insufficient space, please attach a separate sheet.

27 Provide details of your local medical practitioner *(not the specialist)* **who will provide ongoing treatment.**

Local medical practioner's name

DR JOHN ANTOON

Address

BURWOOD FAMILY MEDICAL PRACTICE

PO BOX 217 BURWOOD HEIGHTS POSTCODE 2082

Telephone

(02) 9456 2600

PART I Details of your employment history (other than your service)

Please complete this section even if you are retired.

28 Are you currently employed?

No ☑ ▶ Date ceased work

/ 1986

Reason for ceasing work *(e.g. age, illness, redundancy)*

EARLY RETIREMENT

Yes ☐ ▶ Name of current employer

How many hours per week do you work?

29 Provide details of your employment history other than your service for the last 10 years *or since your last claim.*

140

From (year)	To (year)	Type of work	Name and address of employer
		NONE	

If insufficient space, please attach a separate sheet.

30 Have the disabilities you are now claiming affected your employment or your ability to seek employment at any time?

No ☑
Yes ☐ ▶ Please give details

If insufficient space, please attach a separate sheet.

PART J Other payments

If you lodge a claim for any other pension, benefit or allowance while this claim is being processed, you MUST advise the Department of Veterans' Affairs.

31 Do you receive, or have you applied for, any payment (e.g. the age pension from Centrelink), other than superannuation?
(Family Allowances are not required but other Centrelink payments must be included).

No ☐
Yes ☐ ▶ Give details below

Type of benefit or pension	Name and address of source	Date of claim	Reference No. *(if known)*
SERVICE PENSION	D.V.A.	26/9/07	NKM 07257
		/ /	
		/ /	
		/ /	

If insufficient space, please attach a separate sheet.

PART K Compensation

32 Have damages/compensation been claimed or received from any other source for any of the disabilities you are now claiming (e.g. Comcare, Department of Defence, third party accident insurance)?

No ☑
Yes ☐ ▶ Give details below

Nature of injury or disease	Name and address of source	Date of claim	Reference No. *(if known)*
		/ /	
		/ /	
		/ /	

If insufficient space, please attach a separate sheet.

PART L Pension payment details

33 Do you currently receive a pension from the Department of Veterans' Affairs?

No ☐ ▶ Go to **Question 34**
Yes ☑ ▶ Go to **Question 35**

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IMPORTANT - If a pension is granted, it will be paid fortnightly into an account at an Australian bank, credit union or building society.

34 Provide details of the Australian account you want your pension to be paid into

Name of bank, credit union or building society

Branch

Address

POSTCODE

Account in the name of

Account number

BSB number

Account type (e.g. savings)

Please complete Part M and Part N over page.

Declarations

Complete (a) OR (b) - A representative is not required to sign this form unless they are legally authorised to act for a claimant who is incapable of signing due to their physical or mental incapacity.

35 (a) No representative appointed

- I declare that the details I have given in this form are complete and correct.
- I am aware that there are penalties for making false statements.
- I authorise the Repatriation Commission and the Department of Veterans' Affairs to obtain medical or other information needed to process, determine or review this claim.
- I consent to the release of medical, clinical or other information to the Department by any medical practitioner, hospital, clinic, insurance company, Centrelink, the Department of Defence or other organisation, in relation to this claim or its review.

* Claimant's full name (please PRINT) GEORGE WOODFULL STEVENS

* Claimant's signature George Stevens 15/11/07

35 (b) Representative appointed

- I declare that the details I have given in this form are complete and correct.
- I am aware that there are penalties for making false statements.
- I authorise the Repatriation Commission and the Department of Veterans' Affairs to obtain medical or other information needed to process, determine or review this claim.
- I authorise the nominated representative or organisation to act for me in respect of this claim and any reviews in respect of this or subsequent decisions. This authorisation will continue until I:
  - revoke this authorisation; or
  - nominate another representative or organisation to act for me.
- I consent to the release of medical, clinical or other information to the Department by any medical practitioner, hospital, clinic, insurance company, Centrelink, the Department of Defence or other organisation, in relation to this claim or its review.

* Claimant's full name (please PRINT)

* Claimant's signature / /

* If the veteran is unable to sign, due to physical or mental incapacity, the Declaration must be signed by the person signing the Authority to act on behalf of the claimant at **Question 36** over the page.

SMOKING QUESTIONNAIRE

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The information you provide on this form will assist in deciding eligibility for benefits under the Veterans' Entitlements Act 1986. The authority to obtain this information is also contained in this Act. We treat all personal information in strict confidence but, in the event of an appeal against a decision, this information may be provided to the Veterans' Review Board, Administrative Appeals Tribunal or Federal Court.

Veteran's Details

STEVENS, GEORGE WOODFORD.

Surname | First Names | DVA File No.

(1) Have you ever smoked cigarettes/tobacco on a regular basis?

☐ NO Please sign the form and return it to the Department.

☑ YES Go to Question 2.

(2) In what year did you take up smoking? 1946

(3) This was

☐ Before service

☑ During service

☐ After service

(4) Why did you take up smoking?

PEER PRESSURE -

(5) What quantities of cigarettes/tobacco did you smoke during the following periods? Describe any variations in the habit.

	Years (Dates if known)	Reason	Quantity
Before Service			
During Service	1946	BLOOD PRESSURE	10 CIGS A DAY.
After Service	1956	HABIT	10 CIGS A DAY.

(6) Do you still smoke?

☑ NO When did you stop? 1956 -

☐ YES What is your average daily consumption now? .....

(7) Are there any comments you wish to make in regard to your smoking habit?

No .

SIGNED: George Stevens DATE: 22/11/01

Authority to act on behalf of a claimant

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36 Details of the person who is legally authorised to act on behalf of the claimant who is unable to sign this claim and/or application.

NOTE: The person will usually be appointed by an enduring power of attorney to manage the affairs of the claimant or a family member or friend acting on their behalf, or will hold a medical certificate attesting to the incapacity.

Full name

Address

POSTCODE

Telephone Home ( ) Work ( )

I declare that I am authorised to act on behalf of the claimant in matters relating to this claim and that the claimant is unable to sign due to physical or mental incapacity.

IMPORTANT - Please attach a copy of the instrument conferring this authority e.g. enduring power of attorney or a medical certificate attesting to the person's incapacity to sign. This information will be evaluated by the delegate for the purposes of approval.

Type of authority (e.g. power of attorney)

Signature of authorised person (you must also sign the Declaration at **Question 35**) / /

Allen-Fisher Acoustics

Allen-Fisher Pty Ltd ABN 34063123589
43 Palmerston Rd., Hornsby 2077
(02) 9476 0002
hornsby@allen-fisher.com

T5

164

Report For: Mr George W Stevens
Address: P.O. Box 18
BEROWRA HEIGHTS 2082

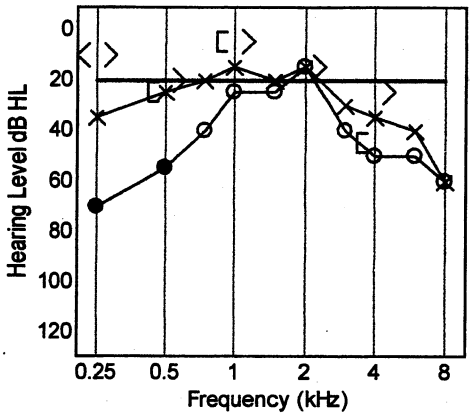
DOB: 10/02/1929
Report Date: 20/12/2007
Test Date: 20/12/2007

Referred By: Ms Elizabeth Pawlak

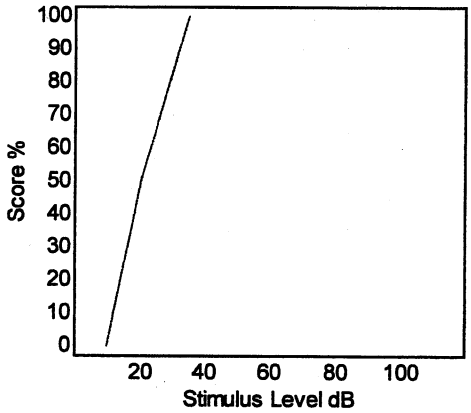
Report To: Ms Elizabeth Pawlak
L16 Dept Veteran Affairs
GPO Box 3994
SYDNEY NSW 1141

Key to Symbols	
X, ■ Left Air, Masked	O, ● Right Air, Masked
>,] Left Bone, Masked	<, [Right Bone, Masked
□ Binaural	↓ No Response

Pure Tone Audiometry



Speech Audiometry



Impedance Audiometry

	Left	Right
Tympanogram Type	A	A
MEP (daPa)	12	36
Ear Canal Volume (ml)	1.5	2.5
Peak Compliance (ml)	0.5	0.9

Reflexes (dBHL)	*500 Hz*	*1 kHz*	*2 kHz*
Left Ipsi	95	95	NR
Left Contra			
Right Ipsi	NR	NR	NR
Right Contra			

	Left	*Right*
Reflex Decay		

Report:

Pure Tone Audiometry indicated an asymmetrical MIXED hearing loss. The LEFT ear is mild in the lows, slight in the mids and moderate in the highs. The RIGHT ear is worse as it is moderate in the lows, mild in the mids and moderate in the highs with significant air-bone gaps recorded in the low to mid range, but not in the high range (Sensori-neural loss in the highs).

Speech tests at indicates good discrimination of A-B Word list material presented at appropriate levels.

Tympanometry indicated normal pressure - compliance variations in both ears (Type A Tympanograms).

Mr Stevens reports the perception of Tinnitus which he describes as "intermittent but annoying".

The results suggest that Mr Stevens should benefit from wearing hearing aids. He may also benefit from Assistive Devices such as Infra Red TV Listening Systems.

I will send a report to Mr Stevens GP Dr Antoon recommending ENT consult be considered because of the asymmetry.

Thank you for your referral. A copy of our Invoice is attached. Yours sincerely,

Helen Williams 20/12/07.

Helen Williams, B.A. Dip Aud. MAudSA(c.c.p.)
Audiologist

Distribution: Ms Elizabeth Pawlak, Dr JOHN ANTOON

QCS

Se n Date: 20/12/2007 Client No: 0001402

Client Na. George Stevens

Birth Date: 10/02/1929

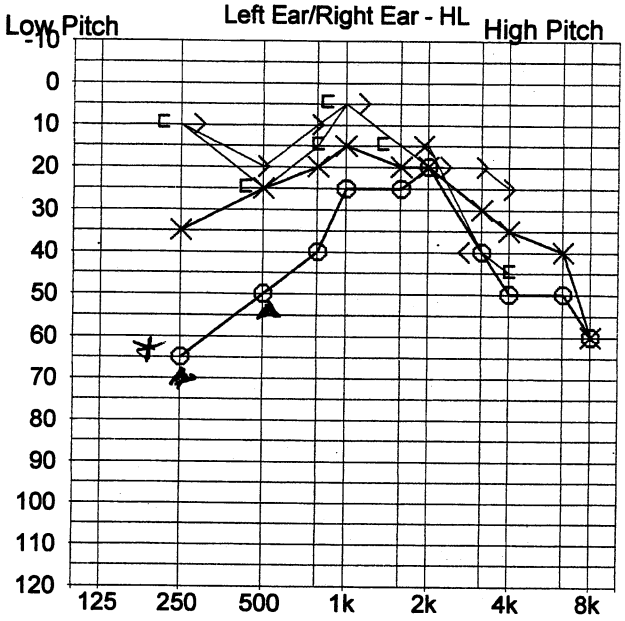
User ID: ABC

Allen-Fisher Acoustics Ltd ABN 34063123580
43 Palmerston Rd, Hornsby 2077
Ph 02 9476 0002, Fax 02 9476 5777

16j

PURE TONE AUDIOGRAM

Frequencies
Tone Audiometer
Left Ear/Right Ear - HL



KEY:
O RIGHT
X LEFT
< B/C R
> B/C L
△ RIGHT MASKED A/C.

OTOSCOPY
RIGHT: Canal } Clear.
TM
LEFT: Canal } RVL.
TM

Tested by Helen Williams
Audiologist
BA DipAud MAud SA c.c.p.

AC:
BC: ~~40~~ ~~40~~ ~~40~~ 30 ~~40~~ ~~50~~
SF:
SFA:
* Possibility of Overmasking.

Masking Levels

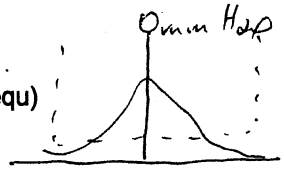
	Right	Masking		Left	Masking
SRT:			SRT:		
	Right	Masking		Left	Masking
MCL:					
	Right	Masking		Left	Masking
UCL:					
	Right			Left	
PTA (A):					

Unaided Discrimination:									
	Right	Level	Masking	Binaural	Level	Masking	Left	Level	Masking
Aided Discrimination:									
	Right	Level	Masking	Binaural	Level	Masking	Left	Level	Masking
Unaided Discrimination, noise:									
	Right	Level	S/N	Binaural	Level	S/N	Left	Level	S/N
Aided Discrimination, noise:									
	Right	Level	S/N	Binaural	Level	S/N	Left	Level	S/N

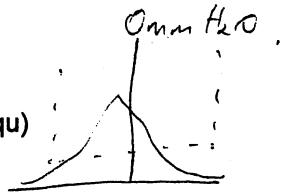
TYMPANOMETRY

Notes

RIGHT
Type: A
MEP: 36 (mm H2o equ)
Comp: 0·86 (cc)
Vol: 2·8 (cc)



LEFT
Type: A
MEP: 12 (mmH2o equ)
Comp: 0·52 (cc)
Vol: 1·50 (cc)



Ipsilateral Reflexes (Screening Levels at 95 dBSPL)

	.5K	1K	2K	4K
R	NR	NR	NR	NR.
L	95	95	NR	NR.

V221
Rec'd 9/7/08
→ APA 9/7/08
$459-80

Folio: 203
T5

Australian Government
Department of Veterans' Affairs

Diagnostic Report - Glaucoma

The information you provide on this form will assist in deciding eligibility for benefits under the Veterans' Entitlements Act 1986. In the event of an appeal against a decision, this information may be provided to the Veterans' Review Board, Administrative Appeals Tribunal or Federal Court.

Veteran's Details

Surname	Given Names	DVA File Number
Stevens	George	KM07257

Report Detail

This veteran has lodged a disability claim for a condition provisionally diagnosed as glaucoma. The Department needs to establish the precise diagnosis in order to process the claim.

1. Please indicate the veteran's glaucoma status in each eye by ticking the appropriate boxes.

Right eye		Left eye	
No glaucoma	☐	No glaucoma	☐
Primary open-angle glaucoma	☐	Primary open-angle glaucoma	☐
Primary angle-closure glaucoma		Primary angle-closure glaucoma	
↳ acute	☐	↳ acute	☐
↳ chronic	☑	↳ chronic	☑
Secondary glaucoma	☐	Secondary glaucoma	☐
Other (please specify)	☐	Other (please specify)	☐

Rt eye - still problem

2. If the veteran has secondary glaucoma please specify the form (e.g. ghost cell, neovascular, phacolytic, pigmentary) and whether the glaucoma is open-angle or angle-closure in type.

N/A.

3. Does the veteran suffer from any other disorders affecting vision?

☐ **No**

☑ **Yes** - Please describe.

cataracts removed + replaced

4. When was the clinical onset of the glaucoma (ie. the first symptoms or signs or other evidence)?

about 20 years ago

5. Would you like to make any other comments on the diagnosis of this condition?

No.

If you have any problems completing this form you can phone the Department and discuss the matter with one of our medical officers.

Details of Medical Practitioner providing advice:

Stamp

DR JOHN ANTOON
1A TURNER ROAD
BEROWRA HEIGHTS NSW 2082
Ph: 9456 2600

Signature

12/6/02

Folio:.....201.....

Australian Government
Department of Veterans' Affairs

Diagnostic Report - Anaemia, Unspecified

The information you provide on this form will assist in deciding eligibility for benefits under the Veterans' Entitlements Act 1986. In the event of an appeal against a decision, this information may be provided to the Veterans' Review Board, Administrative Appeals Tribunal or Federal Court.

Veteran's Details

Surname	Given Names	DVA File Number
Stevens	George	KM07257

Report Detail

This veteran has lodged a disability claim for anaemia, unspecified. The Department needs to establish the correct diagnosis in order to process this claim. Could you please indicate below:

- your diagnosis or differential diagnosis for the claimed condition;
- to what extent this diagnosis has been established; and
- what further steps, if any, are needed to confirm the diagnosis.

1. What is the diagnosis / differential diagnosis for the claimed condition (indicate unknown if no relevant evidence available)?

ANAEMIA
? CHRONIC GASTRITIS / REFLUX
? SIGMOID TUBULO-VILLOUS ADENOMA.

2. To what extent has this diagnosis been established?

- ☐ Insufficient evidence to make a diagnosis at this stage;
- ☐ Provisional / differential diagnosis: further investigation or referral required;
- ☑ Diagnosis confirmed on clinical grounds and/or by relevant investigation.

3. Please provide the results of any investigations which have been performed. *(Please attach copies of relevant specialist reports or test results)*

new attached

4. What further steps are necessary, if any, to confirm the diagnosis (please indicate specific investigations or type/s of specialist referral required)?

5. When was the clinical onset of this condition (ie: the first symptoms or signs or other evidence)?

1 year - Breathless

6. What treatment has been given for this condition?

Nil specific - observ.

7. Are there any predisposing factors for the development of this condition?

No.

8. Would you like to make any other comments on the diagnosis of this condition?

No.

If you have any problems completing this form you can phone the Department and discuss the matter with one of our medical officers.

Details of Medical Practitioner providing advice:

Stamp

DR JOHN ANTOON
1A TURNER ROAD
BEROWRA HEIGHTS NSW 2082
Ph: 9456 2600

Signature

16/8

Australian Government
Department of Veterans' Affairs

Folio: 64

Medical Report - Open-Angle Glaucoma

The information you provide on this form will assist in deciding eligibility for benefits under the Veterans' Entitlements Act 1986. In the event of an appeal against a decision, this information may be provided to the Veterans' Review Board, Administrative Appeals Tribunal or Federal Court.

Veteran's Details

Surname	Given Names	DVA File Number
Stevens	George	KM07257

Report Detail

A claim for service related compensation in respect of disability or death of the above named requires the Department to consider whether any of the following could be factors in the development or worsening of open-angle glaucoma. Would you please answer the following questions:

Surgical procedures affecting specific parts of the body

Please mark and provide details if any of the following surgical procedures or other treatments has ever been provided to the veteran. Identify the date of treatment, the condition treated and the site and/or side of the body affected by the procedure or treatment:

Surgical procedure	Date of treatment	Provided for	Site and/or side of body treated
☐ intraocular surgery or penetrating keratoplasty	/ /		

No.

Details of Medical Practitioner providing advice:

Stamp

DR JOHN ANTOON
1A TURNER ROAD
BEROWRA HEIGHTS NSW 2082
Ph: 9456 2600

Signature

18/8/00

NKM07257

Folio:...168.....

Australian Government
Department of Veterans' Affairs

Diagnostic Report - Chronic Gastritis

The information you provide on this form will assist in deciding eligibility for benefits under the Veterans' Entitlements Act 1986. In the event of an appeal against a decision, this information may be provided to the Veterans' Review Board, Administrative Appeals Tribunal or Federal Court.

Veteran's Details

Surname	Given Names	DVA File Number
Stevens	George	KM07257

Report Detail

This veteran has lodged a disability claim for chronic gastritis. The Department needs to establish the correct diagnosis in order to process this claim. Could you please indicate below:

- your diagnosis or differential diagnosis for the claimed condition;
- to what extent this diagnosis has been established; and
- what further steps, if any, are needed to confirm the diagnosis.

1. What is the diagnosis / differential diagnosis for the claimed condition (indicate unknown if no relevant evidence available)?

CHRONIC GASTRITIS on endoscopy, new biopsy results.
REFLUX OESOPHAGITIS.

2. To what extent has this diagnosis been established?

- ☐ Insufficient evidence to make a diagnosis at this stage;
- ☐ Provisional / differential diagnosis: further investigation or referral required;
- ☑ Diagnosis confirmed on clinical grounds and/or by relevant investigation.

3. Please provide the results of any investigations which have been performed. *(Please attach copies of relevant specialist reports or test results)*

new results.

4. What further steps are necessary, if any, to confirm the diagnosis (please indicate specific investigations or type/s of specialist referral required)?

nil

Folio:..... 97

5. When was the clinical onset of this condition (ie: the first symptoms or signs or other evidence)?

- no significant stomach symptoms
- condition diagnosed coincidentally whilst having investigation for anaemia.

6. What treatment has been given for this condition?

some tonsillectomy

7. Are there any predisposing factors for the development of this condition?

stress related to post service

8. Would you like to make any other comments on the diagnosis of this condition?

no.

If you have any problems completing this form you can phone the Department and discuss the matter with one of our medical officers.

Details of Medical Practitioner providing advice:

Stamp

DR JOHN ANTOON
1A TURNER ROAD
BEROWRA HEIGHTS NSW 2082
Ph: 9456 2600

Signature

18/10/00

Folio:.....144.....

Australian Government

Department of Veterans' Affairs

Diagnostic Report - Diverticular Disease Of The Colon

The information you provide on this form will assist in deciding eligibility for benefits under the Veterans' Entitlements Act 1986. In the event of an appeal against a decision, this information may be provided to the Veterans' Review Board, Administrative Appeals Tribunal or Federal Court.

Veteran's Details

Surname	Given Names	DVA File Number
Stevens	George	KM07257

Report Detail

This veteran has lodged a disability claim for diverticular disease of the colon. The Department needs to establish the correct diagnosis in order to process this claim. Could you please indicate below:

- your diagnosis or differential diagnosis for the claimed condition;
- to what extent this diagnosis has been established; and
- what further steps, if any, are needed to confirm the diagnosis.

1. What is the diagnosis / differential diagnosis for the claimed condition (indicate unknown if no relevant evidence available)?

mild-moderate diverticulin disease
new report 31/Aug/07 D- Hoong.

2. To what extent has this diagnosis been established?

- ☐ Insufficient evidence to make a diagnosis at this stage;
- ☐ Provisional / differential diagnosis: further investigation or referral required;
- ☑ Diagnosis confirmed on clinical grounds and/or by relevant investigation.

3. Please provide the results of any investigations which have been performed. *(Please attach copies of relevant specialist reports or test results)*

new histology report 31/Aug/07
D- Hoong.

4. What further steps are necessary, if any, to confirm the diagnosis (please indicate specific investigations or type/s of specialist referral required)?

N/A.

5. When was the clinical onset of this condition (ie: the first symptoms or signs or other evidence)?

diagnosed while being investigated for anaemia
no current symptoms

6. What treatment has been given for this condition?

high fibre diet

7. Are there any predisposing factors for the development of this condition?

No.

8. Would you like to make any other comments on the diagnosis of this condition?

No.

If you have any problems completing this form you can phone the Department and discuss the matter with one of our medical officers.

Details of Medical Practitioner providing advice:

Stamp

DR JOHN ANTOON
1A TURNER ROAD
BEROWRA HEIGHTS NSW 2082
Ph: 9456 2600

Signature

18/6/00

Folio:.....177.....

Australian Government

Department of Veterans' Affairs

Diagnostic Report - Congestive Cardiac Failure

The information you provide on this form will assist in deciding eligibility for benefits under the Veterans' Entitlements Act 1986. In the event of an appeal against a decision, this information may be provided to the Veterans' Review Board, Administrative Appeals Tribunal or Federal Court.

Veteran's Details

Surname	Given Names	DVA File Number
Stevens	George	KM07257

Report Detail

This veteran has lodged a disability claim for congestive cardiac failure. The Department needs to establish the correct diagnosis in order to process this claim. Could you please indicate below:

- your diagnosis or differential diagnosis for the claimed condition;
- to what extent this diagnosis has been established; and
- what further steps, if any, are needed to confirm the diagnosis.

1. What is the diagnosis / differential diagnosis for the claimed condition (indicate unknown if no relevant evidence available)?

HEART FAILURE CONGESTIVE new report 8/12/00
2-1 h IHD.
Dr RAJESH BRAHMBHATT

2. To what extent has this diagnosis been established?

- ☐ Insufficient evidence to make a diagnosis at this stage;
- ☐ Provisional / differential diagnosis: further investigation or referral required;
- ☑ Diagnosis confirmed on clinical grounds and/or by relevant investigation.

3. Please provide the results of any investigations which have been performed. *(Please attach copies of relevant specialist reports or test results)*

new report 8/12/00

4. What further steps are necessary, if any, to confirm the diagnosis (please indicate specific investigations or type/s of specialist referral required)?

nil

5. When was the clinical onset of this condition (ie: the first symptoms or signs or other evidence)?

1st 1/4 of 2000
(breathless)

6. What treatment has been given for this condition?

ventolin 1st / lasix (diuretic)

7. Are there any predisposing factors for the development of this condition?

ex smoker

8. Would you like to make any other comments on the diagnosis of this condition?

no

If you have any problems completing this form you can phone the Department and discuss the matter with one of our medical officers.

Details of Medical Practitioner providing advice:

Stamp

DR JOHN ANTOON
1A TURNER ROAD
BEROWRA HEIGHTS NSW 2082
Ph: 9456 2600

Signature

18/8/00

Folio:.....19.....

Australian Government

Department of Veterans' Affairs

Medical Report - Corticosteroid Therapy Open Angle Glaucoma

The information you provide on this form will assist in deciding eligibility for benefits under the Veterans' Entitlements Act 1986. In the event of an appeal against a decision, this information may be provided to the Veterans' Review Board, Administrative Appeals Tribunal or Federal Court.

Veteran's Details

Surname	Given Names	DVA File Number
Stevens	George	KM07257

Report Detail

A claim for service related compensation in respect of the abovenamed leads the Department to consider whether undergoing corticosteroid therapy could be relevant to the development of open angle glaucoma in this case. Would you please answer the following questions:

1. When was the clinical onset of open angle glaucoma?

20 - 25 years

/ /

2. Has the glaucoma permanently worsened at any time?

☑ **No**

☐ **Yes** – Please indicate when this happened.

- present and last 20 - 25 years
- condition stable with treatment / /

no cause known.

	Treated	Right Eye	Commenced		application eg daily
N/A					

Corticosteroid containing dermal preparations

Medication Used	Condition Treated	Site of application	Date Commenced	Date Finished	Frequency of application eg daily
N/A					

Oral corticosteroids

Medication Used	Condition Treated	Date Commenced	Date Finished	Frequency of dose eg daily
N/A.				

Corticosteroid injections

Medication Used	Condition Treated	Date of Injection
N/A.		

A subconjunctival repository steroid injection or an orbital/periocular corticosteroid injection

Medication Used	Condition Treated	Date of Injection	Left or Right Eye
N/A.			

Details of Medical Practitioner providing advice:

Stamp

DR JOHN ANTOON
1A TURNER ROAD
BEROWRA HEIGHTS NSW 2082
Ph: 9456 2600

Signature

18/8/02

Stevens	George	KM07257

Report Detail

A claim for service related compensation in respect of the abovenamed leads the Department to consider whether helicobacter pylori infection could be a factor in the development of Chronic Gastritis. Would you please answer the following questions:

1. When was the clinical onset of Chronic Gastritis?..... 1 year diagnosed and ongoing while investigations underway

2. Has the veteran ever been tested for infection with Helicobacter pylori?

   ☐ **No**

   ☑ **Yes** - Please provide results (attach additional results if insufficient space):

Date of Test	31 / 8 / 07	Result:	negative
Date of Test	/ /	Result:	
Date of Test	/ /	Result:	
Date of Test	/ /	Result:	

3. Has the veteran ever received treatment for the eradication of Helicobacter pylori?

   ☑ **No** - *Please sign the form and return it to the Department*

   ☐ **Yes** - Please provide details:

Date of Treatment	/ /	Comment:	
Date of Treatment	/ /	Comment:	
Date of Treatment	/ /	Comment:	

Topical applications .....

3. Does the condition restrict use of either upper limb, walking, dressing, hygiene or feeding?
☑ **No** ☐ **Yes** ↓ *(describe the nature of the limitation for each of these categories)*

Upper limb(s) .....
Walking .....
Dressing .....
Hygiene .....
Feeding .....

4. Does Solar Keratoses cause embarrassment or inconvenience in unfamiliar social settings, domestic life or intimate situations or curtail his participation in sporting or recreational activities?
☑ **No** ☐ **Yes** ↓ *(provide details of when this occurs and describe the extent of the embarrassment)*

.....

.....

5. Is the structural integrity of the face altered because of Solar Keratoses?
☑ **No** ☐ **Yes** ↓ *(describe the changes; eg. partial or total loss of pinna, skin graft, noticeable scarring)*

.....

.....

6. Has there been any deep invasion or dissemination of Solar Keratoses?
☑ **No** ☐ **Yes** ↓ *(provide details, including the depth of invasion in mm, extent of spread, prognosis and treatment)*

.....

.....

7. Are the described symptoms due solely to Solar Keratoses?
☑ **Yes** ☐ **No** ↓ *(please describe the proportion Solar Keratoses contributes : completely, about three quarters, about two thirds, about half, about one third, about one quarter, not at all)*

.....

8. If you answered **NO** to the preceeding question, please list all other conditions that contribute to the symptoms.

N/A

Doctor's signature

DR JOHN ANTOON
Doctor's name
14 TURNER ROAD
BEROWRA HEIGHTS NSW 2082
Ph: 9456 2600

Date 16/8/10

4. Has upper GIT disorders caused a change in body weight since its onset?
☑ **No** ☐ **Yes** ❶ *(record actual or estimated body weight before first onset and current weight)*

Weight before onset _____ kilograms	Current body weight _____ kilograms

5. Does he use any treatment for the condition?
☐ **No** ☑ **Yes** ❶ *(provide details of medication, including dosage and frequency of usage, and comment on to what extent the condition responds to medication. List any permanent side-effects)*

OMAC 40 mg bd

6. Has a restricted or exclusion diet been prescribed for upper GIT disorders?
☐ **No** ☑ **Yes** ❶ *(please provide details)*

HEALTH DIET / Minimal alcohol / avoid NSAIDs / avoid smoking

7. Have any procedures been undertaken or proposed?
☐ **No** ☑ **Yes** ❶ *(list all procedures undertaken or proposed. For stomas, state if temporary or permanent)*

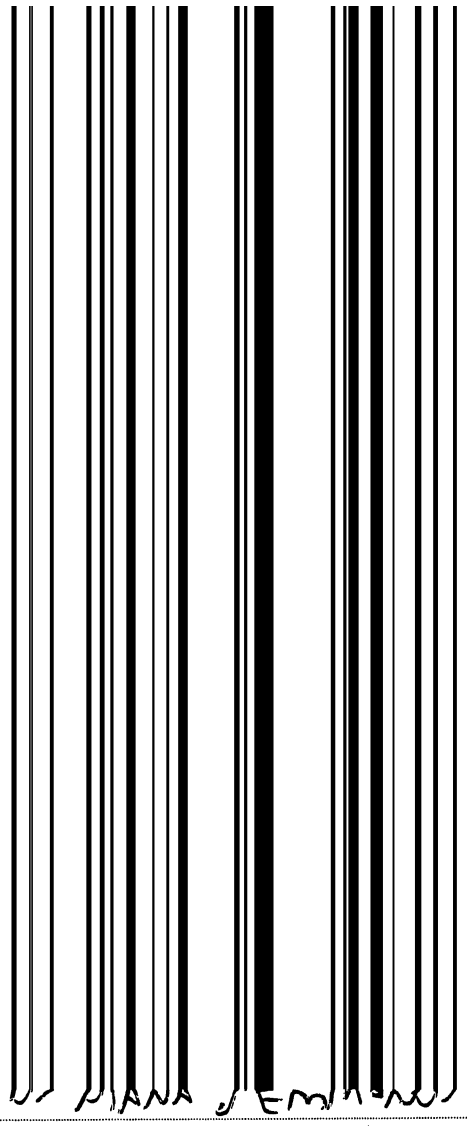
New report Pt chasing 31/Aug/02

8. Are the described symptoms due solely to upper GIT disorders?
☑ **Yes** ☐ **No** ❶ *(please describe the proportion upper GIT disorders contributes : completely, about three quarters, about two thirds, about half, about one third, about one quarter, not at all)*

9. If you answered **NO** to the preceeding question, please list all other conditions that contribute to the symptoms.

N/A.

Doctor's signature	Doctor's name	Date
	DR JOHN ANTOON 1A TURNER ROAD BEROWRA HEIGHTS NSW 2082 Ph: 9456 2600	10/06/02



4. Are there any persistent side-effects of treatment?
☑ No ☐ Yes ❶ *(describe the side-effects and state whether of a temporary or permanent nature)*

5. Are the described symptoms due solely to eye conditions?
☑ Yes ☐ No ❶ *(please describe the proportion eye conditions contributes : completely, about three quarters, about two thirds, about half, about one third, about one quarter, not at all))*

6. If you answered **NO** to the preceeding question, please list all other conditions that contribute to the symptoms.
N/A

7. Please record the corrected visual acuity.

	Right eye	Left eye
Corrected Visual Acuity	6/6.	6/5.

Doctor's signature

DR JOHN ANTOON
OPTOMETRIST
14 TURNER ROAD
BEROWRA HEIGHTS NSW 2082
Ph: 9456 2600

Date 18/06/04.

4. Has he undergone phlebotomy for Anaemia, Unspecified in the last 12 months?
☑ **No** ☐ **Yes** ❶ *(record the time in weeks between each phlebotomy session)*

5. Are the described symptoms due solely to Anaemia, Unspecified?
☑ **Yes** ☐ **No** ❶ *(please describe the proportion Anaemia, Unspecified contributes : completely, about three quarters, about two thirds, about half, about one third, about one quarter, not at all)*

6. If you answered **NO** to the preceeding question, please list all other conditions that contribute to the symptoms.

N/A

DR JOHN ANTOON
1A TURNER ROAD
BEROWRA HEIGHTS NSW 2082
Ph: 9456 2600

Doctor's signature

Doctor's name

Date 18/11/12

CPHEMGEN 10/99

6. Has a restricted or exclusion diet been prescribed for Diverticular Disease Of The Colon?
☐ No ☑ Yes *(please provide details)*
healthy diet

7. Have any procedures been undertaken or proposed?
☐ No ☑ Yes *(list all procedures undertaken or proposed. For stomas, state if temporary or permanent)*
colonoscopy in new report

8. Are the described symptoms due solely to Diverticular Disease Of The Colon?
☐ No ☑ Yes *(please describe the proportion Diverticular Disease Of The Colon contributes : completely, about three quarters, about two thirds, about half, about one third, about one quarter, not at all)*
(no symptoms)

9. If you answered **NO** to the preceeding question, please list all other conditions that contribute to the symptoms.
N/A

Doctor's signature

DR JOHN ANTOON
Doctor's name 1A TURNER ROAD
BEROWRA HEIGHTS NSW 2082
Ph: 9456 2600

Date 18/11/99

CPGITBOW 10/99

8. Does he use any treatment for Lumbar Spondylosis?

☐ No ☑ Yes ❶ *(provide details including any surgery and comment on effectiveness of each modality)*

pain killers.

9. Are the described symptoms due solely to Lumbar Spondylosis?

☑ Yes ☐ No ❶ *(please describe the proportion Lumbar Spondylosis contributes : completely, about three quarters, about two thirds, about half, about one third, about one quarter, not at all))*

10. If you answered **NO** to the preceeding question, please list all other conditions that contribute to the symptoms.

N/A

Doctor's signature

Doctor's name

DR JOHN ANTOON
TARRINER ROAD
BERRIWA HEIGHTS NSW 2082
Ph: 9456 2600

Date 6/3/17

CPMSKLMB 10/99

6. Are there any persistent side-effects of treatment?

☑ No ☐ Yes ❶ *(describe the side-effects and state whether of a temporary or permanent nature)*

Doctor's signature

DR JOHN ANTOON
1A TURNER ROAD
BEROWRA HEIGHTS NSW 2082
Ph: 9456 2600

Doctor's name

Date 18/1/12

☑ Yes ☐ No

(please describe the proportion Congestive Cardiac Failure contributes : completely, about three quarters, about two thirds, about half, about one third, about one quarter, not at all)

4. If you answered **NO** to the preceeding question, please list all other conditions that contribute to the symptoms.

N/A.

Doctor's signature

DR JOHN ANTOON
1A TOMAHA ROAD
BEROWRA HEIGHTS NSW 2082
Ph: 9456 2600

Date 18/1/17

Doctor's signature

DR JOHN ANTOON
1A TURNER ROAD
BEROWRA HEIGHTS NSW 2082
Ph: 9456 2600

Date 18/1/

CPDISFIG 04/99